

## To Legalize Physician-Assisted Suicide Should Not Be Allowed.

One day on February in last year, an Italian woman Eluana Englaro died after her feeding tube was removed. She had lain for 17 years since she had brain death when she was 21 years old, and her father had started a judicial struggle with permission to administer euthanasia a decade ago. He finally won the case and could remove his daughter's feeding tube. During these series of events, the Prime Minister attempted to pass an emergency decree that keep Englaro alive, but the President of Italy would not approve the decree because the decision was made by the Supreme Court. For the last three days – from removal of tube to death – there was, as always, heated debate in Italy between supporters and opponents of euthanasia, and the debate has continued violently. Whenever euthanasia becomes an issue, the sides of the argument always remain as far apart as ever. It is not only because the debate is so acrimonious, but also because the focus of argument is ambiguous. When it comes to Physician-Assisted Suicide (PAS), which is when a doctor helps a patient to commit suicide, legalization of PAS should not be allowed even if the supporting arguments are considerable.

Because euthanasia is comprehensive and polysemous terminology, it is confused with PAS. So, the meanings of euthanasia and PAS to deal with should be clarified before discussion. Euthanasia can be roughly categorized into active or passive, and voluntary or involuntary. According to Shirelle Phelps and Jeffrey Lehman, editors of the *West's Encyclopedia of American Law*, passive euthanasia is "Hastening the death of a person by altering some form of support and letting nature take its course," and active euthanasia is "causing the death of a person through a direct action" (Pars. 2, 5). Passive euthanasia is to stop artificial prolongation of human life, whereas active euthanasia is to shorten remained human life by force. Active euthanasia also can be subdivided by the following criterion that there is a patient's request or not. Bernard Gert, a philosopher of ethics known especially for his work on medical ethics, in the *Encyclopedia of philosophy*, defines Voluntary Active Euthanasia (VAE) as "when a physician accedes to rational request of an adequately informed, competent patient to be killed, for example, with a lethal intravenous injection of pentothal" (par.2). From among several concepts of euthanasia, VAE is the most similar concept to PAS. As in the example already mentioned, euthanasia is a battleground in itself. But leaving the debate aside, many countries acknowledge passive euthanasia explicitly or implicitly. That means, at least, there is a social safety net to prevent indiscreet euthanasia and passive euthanasia can be controlled by the court. The hottest issue is active euthanasia, particularly, to legalize VAE and PAS.

To evaluate the arguments against allowing patients to suicide with physician's assistance, the supporters have a point as well. First of all, most of patients who are suffering from terminally ill or chronic diseases want the legal assistance of doctors. In the "What People Close to Death Say About Euthanasia and Assisted Suicide: A Qualitative Study," A Chapple, S Ziebland, A McPherson, and A Herxheimer, researchers who interviewed terminally ill patients, give results that "law should be changed to allow assisted suicide or voluntary euthanasia was felt strongly by most people," and they also say "Among these interviews with people who were themselves facing death, those who spoke most passionately about the need for a change in the law were those who had also seen others die" (706-709). Many death-facing patients who already witnessed others' painful death don't want to follow same footsteps, and they think to change the law to admit a right to die is the way of keeping dignity as a human being. In this sense, the arguments which Sharon I. Fraser and James W. Walters, a speech pathologist and a professor of ethical studies at Loma Linda University, had in "Physician-Assisted Suicide Should Be Legalized." are quite meaningful:

it is hardly surprising that ... public opinion polls have consistently supported physician-assisted death. In Oregon in a February 1997 poll, 61% answered "yes" to the question, "Shall the law allow terminally ill adult patients the voluntary informed choice to obtain a physician's prescription for drugs to end life?"...50% of the Catholic voters answered "yes" to the same question. (pars. 8-9)

It seems to be widely believed that a human being has a right to select own life and death because people believe that life is an end in itself, and the artificial prolongation of human life is futile. Supporters argue that nobody want to show a miserable death to others, even to family. So, they think that to give a patient who cannot help dying autonomy to select how to die is death indeed with dignity.

Supporters also exemplify assisted suicide in Oregon, the first state which legalized PAS, as a successful case. Carrie Snyder, a writer of "Legalizing Physician-Assisted Suicide in Oregon Has Not Led to Abuses," from the Death with Dignity National Center claims that "Nobody wants to die ... [Only] people in extreme situations for whom recovery is no longer possible use the law as a last resort when each day becomes more and more unbearable," and she also asserts that "Laws can only be used to protect patients and physicians by regulating the practice – ensuring no abuse occurs" (pars. 3-6). That is, because people use the laws as the very last means to get peace, there is neither slippery slope that opponents concern about, nor abuse of PAS. The basic premise of all these arguments is that there is a different quality of life, and to shorten a bad quality of life is more humane.

However, there is obvious statistical evidence that the PAS law is being abused. "After four years of assisted suicide," Kenneth Stevens, a writer of "Oregon's Death with Dignity Act Is Being Abused" and

Vice President of the Physicians for Compassionate Care Education Foundation points out, “there were almost twice as many dying patients in moderate or severe pain or distress as there had been prior to the law change,” and he states that is because that “Once a patient has the means to take his or her life, there is less incentive to care for the patient’s symptoms and needs” (pars. 6-7). Undoubtedly, double of assisted-suicide tells the law is encouraging PAS. As a result of the law, people easily give up hope to survive and doctors are quick to aid and abet suicide. Suppose that A can be approved but B is not acceptable, and B will follow naturally if you permit A. And then, can you permit A without any consideration of following B (McLean and Britton 15)? The chain reaction between legalization and increase of PAS is the most concerning. The result of experimental law in Oregon shows that legalization is nothing less than a slippery slope. In comparison, a legal safety so-called “safeguard” to prevent a slippery slope seems to be lack. Although Oregon’s law also has some limitation articles that restrict PAS to patients, it may be asked whether it works. Actually, Stevens says that “when controlling-type people come up against the requirements of the law, something has to give, and so the boundaries around assisted suicide in Oregon have stretched” (par. 10). If this trend continues, it would not be an overstatement to say that some people may seek PAS not because of human dignity but because of economic reasons or some people may try to commit murder that simulates PAS.

Moreover, the premise that supporters assume is ethically and legally wrong, and of course, the argument based on a fault premise is totally illogical. In terms of the sanctity of human, there is no difference in dignity between dying patients and healthy people. And there is no difference among assistance of death. In this view, the example from "Physician-Assisted Suicide Should Not Be Legalized." which Wesley J. Smith, a lawyer and associate director of the International Task Force on Euthanasia and Assisted Suicide, wrote is very interesting:

If the doctor prescribes a lethal overdose for someone who wants to die because their children have been killed in an auto accident, he would be guilty of a felony ... But if the same doctor issued the same prescription for the same person who wanted to die for the same reasons but who had also been, coincidentally, diagnosed with terminal cancer, suddenly the act of prescribing a lethal overdose is “practicing medicine.”... Either all of these hypothetical prescriptions are medical acts or none are. (par. 7)

It is irrational that to help people who have mental disease such as depression in committing suicide is a crime whereas to assist physically ill people in killing themselves is not a crime. If you assist someone in committing suicide without his or her request – in other words, in case of VPE, you commit the crime of assisting suicide. Besides, to assist suicide with request such as VAE constitutes the crime of permitted homicide. There is no exception by the criminal law in my country and the other countries’ application of

the criminal law should be similar. In the *Euthanasia and The Right to Die: A Comparative View*, Jennifer M. Scherer and Rita J. Simon suggest additional point of view: “human are by nature social creatures with responsibilities to society, to each other, to the self, and to certain standards of behavior generally regarded as dignified. Thus a major contention is that suicide is a crime against society” (14). Therefore, if assisted-suicide is allowed by reason of death with dignity, the society which is based on the rule of law and supported by citizens is compromised.

In addition, PAS also can destroy the spirit will of medicine. The purpose of medicine is not letting patients meet comfort death but prolong their lives. When doctors deny this sacred responsibility, the foundation of medicine will be shaken. In this view, the physician Timothy E. Quill, who strongly supports euthanasia and is famous for articles about his personal experiences of assisting suicide, perverts the true meaning of medicine and his perception of doctor’s role looks somewhat dangerous. According to the *Death and Dignity*, there are conflicting two purposes that doctors have to pursue in the Hippocratic Oath, which is the oldest but still effective fundamental ethical oath to doctor. One is to prolong lives and the other is to alleviate pain. He claims that “When treating a dying person, the balance within the Hippocratic Oath usually shifts [to minimize suffering]. The discomfort that may be a byproduct of a specific life-prolonging medical treatment may not be acceptable” (Quill 43-44). Can no one accept the discomfort from treatment? If all doctors understand their roles same way, no patient can believe any of them. The doctor should be a life-saver, not a life-taker. Trudy Chun and Marian Wallace quote Thomas Reardon, past president of the American Medical Association (AMA) that “Physicians are healer[s] ... The inability of physicians to prevent death does not imply that they are free to help cause death ... [PAS is] fundamentally incompatible with the physician’s role as healer” (pars. 28-29). If a physician gets request for PAS, he or she must firstly consider their role as curer. And finally, when a physician finds there is no more cure for a patient, the next step the physician have to take is to agonize over his or her inability, not to recommend a patient PAS. The Hippocratic Oath tells that doctor is not God. The doctor has no right of choosing death or alive. If this undeniable fact is ignored, contemporary medicine will be face crises – the crisis of medical ethic and the crisis of confidence.

To legalize Physician Assisted Suicide or not is particularly disputatious topic. It is related to human life and the social system, and especially the law, which is irreversible. It is very difficult to restore a society to what the society used to be once legal or social system is changed. Also we can intuit that it is inevitable that euthanasia, in any way, will become one part of our lives. Therefore, we have to approach cautiously, take time, and if needed, experiments should be conducted until empirical evidence is found. Oregon’s PAS law will be a good example of the experiment that John B. Mitchell mentions in the *Understanding Assisted Suicide: Nine Issues to Consider*: “[If] the experiment [like that in Oregon] fails,

and other data confirm our worst fears, then law must aggressively address the euthanasia underground and any de facto practices resembling euthanasia in managed care facilities” (160). This is a decisive moment for us and we are now standing in the moment. We have to have these conversations, have to argue, but before we go ahead, we need to be discreet.

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